REPORT BY THE

AUDITOR GENERAL

OF CALIFORNIA

THE DEPARTMENT OF HEALTH SERVICES CAN IMPROVE THE ENFORCEMENT OF HEALTH CARE STANDARDS IN LONG-TERM CARE FACILITIES

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REPORT OF THE

OFFICE OF THE AUDITOR GENERAL

TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

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THE DEPARTMENT OF HEALTH SERVICES CAN IMPROVE THE ENFORCEMENT OF HEALTH CARE STANDARDS IN LONG-TERM CARE FACILITIES

AUGUST 1982

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August 23, 1982

The Honorable President pro Tempore of the Senate 202
The Honorable Speaker of the Assembly
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members of the Legislature:

The Joint Legislative Audit Committee respectfully submits the Auditor General's report on the Department of Health Services, Licensing and Certification Division.

The Department of Health Services is responsible for ensuring that approximately 1,200 long-term care facilities provide adequate health care for California's approximately 106,000 chronically ill or convalescent patients. These long-term care facilities include nursing homes, intermediate care facilities, skilled nursing facilities, extended care facilities and distinct sections of hospitals.

Through its Licensing Certification Division, which operates with a $14 million budget ($8.9 state, $5.1 federal), the department enforces minimum health standards as found in state and federal law and regulations. Enforcement is conducted through surveys, examinations, and investigations of health care facilities. Civil penalties of up to $5,000 can be assessed by the issuance of citations. The Auditor General's report discloses serious problems in policy, procedures and practices of the Licensing Certification Division.

The department is required by state law to investigate complaints within ten working days of their receipt. This is not being done, with 42% of the cases reviewed by the Auditor General being investigated late. The department must also improve its practices and procedures to discourage facilities from repeating violations and allowing substandard conditions to exist. Problems in this regard were identified in the application of health standards and issuing of citations, tripling fines for repeat citations, and enforcing issued citations.

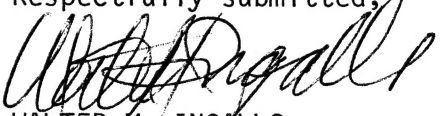
Other deficiencies concern the department's current procedures for approving the facilities proposed corrective actions and the followup visits which are meant to ensure that such actions are taken. These procedures are not always effective and must be improved.

The department must also establish policy guidelines and provide staff training so that statewide enforcement of health standards is done in a uniform and consistent manner.

The Auditor General has determined that "the department is not sufficiently enforcing state and federal health standards." As a result, some facilities are not in compliance with health standards and are endangering the health, safety and security of their patients.

The Department of Health Services has an obligation and a mandate to protect the infirm and convalescing patient. The department is not fulfilling this responsibility, and is therefore placing in jeopardy those they are supposed to protect.

Respectfully submitted,



WALTER M. INGALLS
Chairman, Joint Legislative
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SUMMARY

The Department of Health Services (department), through its Licensing and Certification Division, is responsible for ensuring that long-term care facilities provide adequate health care for California's chronically ill or convalescent patients. The department is not satisfactorily enforcing federal and state health standards, however. Because some facilities are frequently not in compliance with health standards, they are endangering the health, safety, and security of their patients.

The department needs to investigate complaints made against long-term care facilities more promptly. Although the Health and Safety Code and department policy require the department to investigate complaints within 10 working days of their receipt, 41.5 percent of the complaints in our review of district office records from 1980 to 1982 were investigated late. The district offices have developed inconsistent and sometimes inadequate procedures for investigating complaints because the department has neither monitored the district offices nor provided guidance for the timely investigation of all complaints. Although district office administrators said that staff vacancies prohibit their offices from investigating all complaints promptly, we could not verify that this was

always the cause of late responses. As a result, patients in some facilities have received substandard care for prolonged periods of time. For example, one district office deferred a complaint for 106 working days until its next annual survey even though the complaint alleged serious deficiencies in patient care. One allegation in this complaint was that the plans of care for each patient were not complete. Specifically, the facility had improperly fitted a patient with a catheter and failed to monitor the patient's condition. The patient subsequently developed complications and was transferred to an acute care hospital. During the annual survey, the survey team validated the allegation, and the district office issued a Class "A" citation, the most serious violation, for the facility's failure to maintain a plan of care for each patient based on an assessment of the patient's need.

The department also needs to improve its practices and procedures to discourage facilities from repeating violations and allowing substandard conditions to exist. In consecutive annual surveys, 84 percent of the facilities we reviewed repeated one to fifteen violations, including some violations of critical health standards. Because the department lacks guidelines and a monitoring system, department staff inconsistently issues citations and assesses fines for serious violations of health standards. For example, one

facility was assessed a $5,000 fine for a case of advanced decubitus while another was assessed $1,000 for a more severe case.

Further, the department does not always review the adequacy of many plans of correction. For instance, the department approved the purchase of an electric bug-catcher as the corrective action for a patient with a maggot-infested sore. Additionally, the department also inadequately verifies that corrective action was taken. For example, one facility was allowed to retain an unqualified dietary supervisor for four years. During this time, the department accepted the facility's plan to enroll the dietary supervisor in correspondence courses. Although the department in some cases is required to triple fines for repeated violations, many facilities are repeating violations without incurring any additional penalty. The department did not triple fines for over 75 percent of the eligible repeated citations in our sample. Department personnel stated that they were unsure of what constitutes a repeated violation.

Finally, the department needs to improve its management information system for licensing and certification activities. The current system does not provide the information required for monitoring and assessing trends of substandard care at facilities and for identifying deficiencies

in the statewide program and at district offices. As a result, the department cannot quickly and routinely identify current or potential problems. Additionally, the State needs timely and accurate information to focus its time and resources on those facilities that continuously provide substandard care.

The department has recognized some of the problems identified in this report and has begun to improve both the monitoring of long-term care facilities and the quality of the management information system. Additional improvements are needed, however.

The department should improve the processing and investigating of complaints, and it should ensure that district offices respond properly to these complaints. Further, the department's enforcement practices and procedures should be improved to facilitate the consistent application of health standards, citations, and assessed fines. To improve the monitoring of the performance of district offices and long-term care facilities, the department should develop a comprehensive management information system. The department should also clarify the definition of a repeated violation, and it should clarify the criteria for tripling fines.

Finally, the Legislature should amend the Health and Safety Code to require a fine for a Class "B" citation even if the violation is corrected.

This is the second review of the Department of Health Services' Licensing and Certification Division conducted by the Office of the Auditor General. The first review was conducted in 1977. The present review found that some of the deficiencies identified by the Auditor General in 1977 continue to exist.

INTRODUCTION

In response to a request by the Joint Legislative Audit Committee, we reviewed the Department of Health Services' program for monitoring and enforcing minimum health standards to ensure that quality care is provided to patients in long-term care facilities. We conducted this review under the authority vested in the Auditor General by Sections 10527 through 10528 of the Government Code.

BACKGROUND

The Department of Health Services (department) is responsible for ensuring that long-term care facilities provide adequate health care for California's chronically ill or convalescent patients. In general, long-term care facilities include any licensed health facility that provides 24-hour skilled nursing services or provides supportive, restorative, or preventive health services in conjunction with socially oriented programs. These long-term care facilities include nursing homes, intermediate care facilities, skilled nursing facilities, extended care facilities, and distinct sections of hospitals. According to department staff, as of March 1982, approximately 1,200 long-term care facilities provided care to approximately 106,000 patients. Through its Licensing and

Certification Division (LCD), the department enforces the minimum health standards specified in the California Health and Safety Code, in Title 22 of the California Administrative Code (Title 22), and in Titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act. Through the Health Care Financing Administration, the federal government contracts with the State to certify health facilities for participation in the Medicare and Medi-Cal programs. Subsequent to our field work, the health standards for licensing contained in Title 22 of the California Administrative Code were revised. These revisions did not affect our findings or recommendations, however.

The LCD enforces the health standards by conducting surveys to monitor long-term care facilities. The LCD has eleven district and subdistrict offices located throughout the State. Except for two districts, each district office maintains at least one sub-office in its area of responsibility. These offices include one in Los Angeles County that contracts with the department to perform the licensing and certification activities from Los Angeles County's four regional offices. The district offices are comprised of an administrator, one or more supervisors, and survey or inspection staff. Survey teams, generally composed of a specialist (a registered nurse) and a generalist (a facility inspector), make unannounced visits to facilities. The department is required to conduct at least one annual

inspection of each long-term care facility to assess its compliance with state licensing and federal certification requirements for participation in the Medicare and Medi-Cal programs. In addition, the survey teams investigate complaints received by the district offices. For each violation identified, the district office staff prepare a statement of deficiencies and obtain a plan of correction from the facility. Survey teams make follow-up visits to verify that facilities have taken corrective action.

The department may issue citations with fines for serious violations of Title 22 standards discovered during any inspection of a health facility. Violations are classified into three categories according to their severity. Violations that present imminent danger or substantial probability of death or serious harm (Class "A") are subject to fines ranging from $1,000 to $5,000. Violations, other than Class "A" violations, that have a direct or immediate relationship to the health, safety, or security of a patient (Class "B") are subject to fines ranging from $50 to $250. Violations that have a minimal relationship to the health and safety of patients (Class "C") are not subject to citations or fines. According to the department, approximately 32 percent of the long-term care facilities were issued citations for Class "A" or Class "B" violations in 1981.

A facility may appeal a citation through a citation review conference, which is an informal administrative hearing. Should the facility desire to contest the decision of the citation review conference, it must inform the director of the department. The director is required to notify the Attorney General, who then must take the appropriate action to recover the fine. The facility also has the option of appealing a citation directly to the California Superior Court.

For fiscal year 1981-82, the LCD's budgeted expenditures totaled approximately $14 million. The federal contribution to the LCD's operating budget is approximately 36.5 percent of the total budget. According to the 1982-83 Governor's Budget, the LCD's estimated expenditures for fiscal year 1981-82 were approximately $8.9 million from the State's General Fund and $5.1 million from the Federal Trust Fund.

Previous Auditor General Audits

In October 1977, the Office of the Auditor General issued a report entitled, "Deficiencies in Monitoring and Enforcing Quality of Care to Nursing Home Patients" (Report No. 275.2). That report, which also evaluated the department's Licensing and Certification Division, identified several significant deficiencies. First, the department had not developed procedures to identify possible criminal

violators for those skilled nursing facilities that had repeated violations of the health and safety standards. Second, the audit identified weaknesses in legislation concerning the imposition of civil sanctions against repeat violators, as well as weaknesses in the enforcement of Class "B" violations in court. Third, the Attorney General and the department had not promptly prepared accusations to revoke the licenses of skilled nursing facilities, nor had they filed civil complaints to enforce citations and collect penalties. Finally, the 1977 audit found no statewide procedure to control the investigation of complaints.

Our current review revealed that some of these deficiencies continue to exist. Specifically, the department has not established procedures to identify repeat violators routinely, and it has not ranked and investigated complaints in a timely manner. Additionally, weaknesses still exist in the legislation that provides for the enforcement of Class "B" citations.

SCOPE AND METHODOLOGY

The objective of our review was to determine the effectiveness of the Department of Health Services' program for monitoring and enforcing minimum health standards in long-term care facilities. Our review was limited to skilled nursing

facilities, intermediate care facilities, and distinct sections of hospitals providing skilled or intermediate care. We examined three major elements of the program: the timeliness of complaint investigations; the effectiveness of enforcement policies and procedures; and the effectiveness of the Licensing and Certification Division's management information system.

In conducting this review, we interviewed federal and state officials and examined program policies and directives. We also visited five district offices and interviewed district administrators and survey staff to identify the policies and procedures they follow in performing surveys, follow-up visits, and complaint investigations. We also administered a questionnaire to 20 staff of district offices to assess the consistency of the application of Title 22 regulations. In addition, we reviewed the effectiveness of the management information system in providing data on long-term care facilities to both the department and the district offices.

We randomly selected 99 facility files that contained 388 complaints and 195 citations. We reviewed these files to determine the timeliness of surveys to investigate complaints, the consistency of applying Title 22 health standards, the adequacy of facilities' plans of correction (including follow-up actions by the department), the trends of repeat violations, and the legal actions taken to enforce citations.

CHAPTER I

THE DEPARTMENT OF HEALTH SERVICES IS NOT SATISFACTORILY ENFORCING MINIMUM HEALTH CARE STANDARDS IN LONG-TERM CARE FACILITIES

The State Department of Health Services (department) is responsible for ensuring that chronically ill or convalescent patients in California's long-term care facilities receive adequate care as defined in state and federal health and safety standards. However, the department is not satisfactorily enforcing these health standards. Additionally, some long-term care facilities are frequently not complying with critical health standards. Consequently, these facilities are exposing their patients to conditions that could endanger their health, safety, and security. The department has not satisfactorily enforced state health and safety standards because it does not promptly investigate complaints about substandard care. Additionally, current enforcement practices and procedures ineffectively prevent repeated violations of health and safety standards. Finally, the department lacks the information necessary for identifying and assessing trends of substandard care in long-term care facilities.

INCONSISTENT, INADEQUATE, AND UNTIMELY RESPONSES TO COMPLAINTS DO NOT ENSURE THAT MINIMUM HEALTH STANDARDS ARE CONTINUOUSLY MET

The department needs to investigate complaints made against long-term care facilities more promptly. The Health and Safety Code and department policy require the department to investigate complaints within 10 working days of their receipt. However, 41.5 percent of the cases we examined were deferred for an average of 33 working days and for as long as 184 working days beyond the required time limit. In addition, we found 16 complaints (4.1 percent) for which there was insufficient documentation in the facility file to demonstrate that the district office had performed an investigation.

The district offices have developed inconsistent and sometimes inadequate procedures for investigating complaints because the department headquarters management has not monitored the district offices or provided guidance for the prompt investigation of all complaints. Although district office administrators said that staff vacancies prohibit their offices from investigating all complaints promptly, we could not verify that this was always the cause of late responses. As a result of inconsistent, inadequate, and untimely responses to complaints, patients have suffered for unnecessarily long periods of time from substandard conditions in some long-term care facilities.

The Health and Safety Code, Section 1419, allows any person to request an inspection of any long-term care facility by submitting a written, signed complaint. Section 1420 requires the department to perform an on-site investigation of such complaints within 10 working days of their receipt unless the department determines that the complaint is without any reasonable basis or is willfully intended to harass the facility. In addition, the department's policy requires the district offices to investigate all unwritten complaints that may be received by telephone or in person within 10 working days of their receipt unless the department determines that the complaint is without reasonable basis or is filed merely to harass the facility. Department officials stated that the required time limit was not derived from specific medical criteria, but was instead established as a reasonable amount of time to investigate a complaint. It is the policy of each of the district offices in our review to investigate complaints in order of their priority. The district offices generally assign priorities based on the medium (i.e., whether the complaint was received by letter, telephone, or in person), the source of the complaint, and the medical urgency.

Complaints require prompt investigations for three reasons. First, patients may suffer harm from substandard conditions that are undetected and uncorrected. For example, if the quality of care provided by a facility is poor, a

patient can develop advanced decubitus ulcers within a few days depending upon the patient's initial condition.* If the decubitus ulcers continue to develop without proper treatment, the patient is likely to suffer permanent physical harm. Second, some complaints become more difficult to validate the longer they are deferred. For example, complaints involving patient abuse require an immediate investigation in order to identify and interview eyewitnesses and to document bruises or injuries before they heal. Third, our audit data confirm a widely held opinion in the department that complaints are a potentially valid source of information about the quality of care provided by facilities. Of the complaints in our review, 39.4 percent were found to be valid upon investigation. Further, 63.4 percent of these valid complaints revealed that the facilities were violating critical standards for quality health care.

* Decubitus ulcers are open sores that result from the breakdown and death of healthy skin tissue. In their advanced stage, these sores will progress into the muscle and bone. Decubitus ulcers develop when sufficient, prolonged pressure is applied to the skin; this occurs when a patient repeatedly lays or sits in the same position without moving. Increasing age, poor hygiene, poor nutrition, and poor hydration make the skin tissue more susceptible to decubitus ulcers. Medical conditions such as diabetes, anemia, and circulatory disorders also increase a patient's susceptibility to decubitus.

We reviewed the handling of 388 complaints received or investigated in calendar years 1980-81 in the five district offices. We found that the district offices are deferring many investigations in response to valid complaints beyond the required time limit. Specifically, 161 of the 388 complaints (41.5 percent) were investigated an average of 33 working days and for as long as 184 working days beyond the required time limit. In addition, 39.4 percent of these 388 complaints were found to be valid, and the department issued citations or statements of deficiencies for violations of state or federal health standards. The following table summarizes our analysis.

TABLE 1

TIMELINESS AND RESULTS
OF COMPLAINT INVESTIGATIONS

District Office	Total Complaints Received	Total Complaints Investigated Late	Percent of Total Complaints Investigated Late	Total Complaints Validated	Percent of Total Complaints Validated	Number of Validated Complaints Investigated Late	Percent of Total Complaints Investigated Late	Range of Working Days Late
A	111	47	42.3%	34	30.6%	14	41.2%	1-46
B	65	23	35.4%	29	44.6%	10	34.5%	1-32
C	41	21	51.2%	16	39.0%	7	43.8%	2-12
D	54	11	20.4%	23	42.6%	7	30.4%	1-28
E	117	59	50.4%	51	43.6%	28	54.9%	1-184
Total	388	161	41.5%	153	39.4%	66	43.1%	

Each district office has a system for assigning priorities to complaints that would allow potentially less serious complaints to be deferred beyond the required time limit. Yet 43.1 percent of the validated complaints in our review were investigated late. Further, many of these late investigations disclosed that the facilities were not in compliance with critical standards for quality health care.

In one district office, for example, a complaint was deferred for 106 working days until the next scheduled survey, even though serious deficiencies in patient care were indicated. Moreover, the source of the complaint was a report prepared by a registered nurse who was a member of the department's Field Services Branch review team. These teams perform an annual review of all the Medi-Cal patients in long-term care facilities to determine whether the medical and social needs of these patients are being met. The Field Services Branch routinely sends a copy of its subsequent report, including observations of the quality of care, to the appropriate LCD district office.

The nurse reported that the individualized plans of care were not complete for all patients; the district office had issued a Class "A" citation for this same deficiency during the prior annual survey. When the LCD team performed the next survey, 106 working days later, it confirmed the nurse's

observation. Specifically, the facility had improperly fitted a patient with a catheter and then failed to monitor the patients' condition.* By the time the facility discovered its error, the patient had developed complications and, consequently, was transferred to an acute care hospital. As a result, the district office issued a Class "A" citation for the facility's failure to maintain a plan of care for each patient based on an assessment of the patient's needs.

Finally, we found 16 complaints for which there was insufficient documentation in the district offices' facility files to demonstrate that the district office had performed investigations. Moreover, 8 of these complaints alleged serious violations of health standards at a single facility. One complaint alleged that a patient was abused; another alleged that the facility was understaffed. The district office supervisor could not verify that any of these 8 complaints had been investigated.

* A catheter is a tubular device that is attached to a collection bag and inserted in the urethra to assist patients who cannot voluntarily retain or release their urine.

Insufficient Monitoring and Guidance

The department does not routinely monitor the complaint investigations performed by its district offices. The management at LCD headquarters does not collect sufficient information from the district offices to detect patterns of complaints and thereby ensure that facilities are monitored more closely. In addition, management does not collect information needed to ensure that the district offices are responding to complaints in a timely manner. (In the third section of this report, we further discuss the inadequacies of the department's management information system.)

The department suggests, but does not require, that district office supervisors assign priorities to incoming complaints. However, the department does not provide clear guidance about the specific criteria that district offices should use in ranking incoming complaints. Consequently, district offices are ranking and investigating complaints based on inconsistent and sometimes inadequate criteria.

The district office staff consider at least one of three criteria when ranking complaints or when scheduling a complaint investigation. The three criteria are the medium (i.e., whether the complaint is received by letter, telephone, or in person), the source, and the medical urgency of the

complaint. Complaints that the district offices consider to be less serious are assigned a lower priority or may be deferred until the next scheduled visit to the facility. In three out of five district offices we visited, written complaints received a relatively higher priority than unwritten complaints. In two of these three district offices, staff stated that they validate unwritten complaints less often than they validate written complaints. However, our data show that written complaints were validated in 40.8 percent of the cases, while unwritten complaints were validated in 38.3 percent of the cases.

In one of the two offices where unwritten complaints are considered to be less valid than written complaints, staff attempt to get all complaints in writing before performing an investigation. Complainants who present their complaints in person are asked to fill out complaint forms. Complainants who telephone are asked to write a letter or fill out the complaint form, which is then mailed to them. The district office staff state that they respond to complaints received by telephone only when they appear to present a threat to a patient's life. Yet many investigations of serious complaints are needlessly delayed while a form is mailed, completed, and returned. Further, the remaining four district offices routinely accept and investigate unwritten complaints, which we found are validated approximately as often as written complaints are.

Although district office staff believe that anonymous complaints are less valid than complaints received from identified sources; at three of the five district offices we visited, anonymous complaints consequently received a relatively lower priority than complaints from identified sources. However, our data show that anonymous complaints were validated in over 29 percent of the cases. One district office, for example, received an anonymous complaint alleging that a facility was providing poor patient care. The district office investigated the complaint 25 working days later and found that a patient had developed an advanced decubitus ulcer. Because the patient was not receiving proper hygiene and treatment for the prevention of decubitus ulcers, the district office issued a Class "A" citation.

We also found a variation within and between the district offices with respect to their responses to the reports from the department's Field Services Branch. One district office screens each report and conducts a complaint investigation if violations of health standards are indicated. We found that 56 percent of these complaints were validated. In another district office, one supervisor initiates a complaint investigation when the report concludes that the overall quality of care in the facility is poor; the other supervisor in this office does not review the department's

reports for potential complaint action. A third office routinely files the reports for later reference and takes no further action.

The district offices also assign priorities and investigate complaints inconsistently depending upon the medical urgency of the complaint. We noted variation in the priorities assigned to complaints based on their contents. We presented ten examples of patient care complaints to 16 headquarters and district office staff who ranked the complaints in the order that they should be investigated. In eight of ten complaints, staff assigned ranks that differed in a range of at least five ranks. For example, one complaint stated that there was no licensed vocational nurse or registered nurse on duty during the night shift. The staff ranked this complaint from one, the highest priority, to nine, next to lowest.

Through interviews with district office staff, we noted other inconsistencies in assigning priorities based on the medical urgency of a complaint. For example, one district office required complaints alleging that facilities were serving cold food to be investigated within a few working days. The district office supervisor stated that cold food directly affects patient health because some patients will not eat cold food and will rapidly weaken from weight loss. Supervisors in

two other district offices, however, regarded these complaints as having a minimal relationship to patient health. One supervisor said that his office would investigate this type of complaint within 30 days, and the other supervisor stated that his office often deferred such complaints until the next scheduled visit to the facility.

Finally, the five district offices in our sample set time limits of up to 1 to 5 days to investigate complaints that present an imminent threat to patients' health and safety. These complaints are assigned the highest priorities. The district offices rank and schedule investigations of all other complaints, including those that directly and indirectly affect patient health and safety, giving consideration to their medium, source, or medical urgency. Most district offices said that their time limits for investigating complaints that do not affect patient health and safety range from 1 to 3 months; some complaints could be deferred until the next scheduled survey visit.

For example, one district office's policy is to assign the highest priority to life threatening complaints, a 10-working-day priority to letter complaints, and a "discretionary status" to all other complaints. In scheduling the investigations of these discretionary complaints, the supervisors considered the seriousness of the complaints and

also staff workload. However, we found that this district office deferred four complaints against one facility up to 127 working days until the next annual survey, even though the complaints were serious. Two complaints alleged that the facility was neglecting its patients and that the facility was not kept clean; the district office deferred one complaint for 18 working days and the other for 127 working days. The remaining two complaints alleged that the facility was understaffed; these were deferred for 69 and 75 working days, respectively.

During the annual survey of this facility, the LCD survey team documented deficiencies in all of the areas mentioned above. The team documented numerous violations in standards set for patient care and maintenance of the facility. Further, one of the plans of correction that the district office and facility agreed upon specified that the facility would increase its staffing to provide adequate care to its patients. In addition, the survey team issued a Class "B" citation to the facility for failing to provide a therapeutic diet as prescribed by the patient's physician.

All district offices required immediate responses to complaints involving physical abuse of patients. However, 21 of the 35 complaints (60 percent) we reviewed that involved physical abuse were deferred between 5 and 91 working days

before being investigated. One facility demonstrated a persistent pattern of complaints alleging that patients were physically abused and neglected during a period of one year. The district office deferred the first four complaints for an average of 32 working days and for as long as 69 working days before conducting an investigation. The district office investigated the fifth and sixth complaints within five working days; both complaints were validated. As a result of the investigations of the fifth and sixth complaints, the district office issued 29 Class "A" and Class "B" citations for serious commissions of patient abuse and neglect. (The district office was unable to document what was alleged in the fifth complaint. Although we cannot verify that the fifth complaint alleged patient abuse, its investigation resulted in the district office's issuing citations to the facility for patient abuse.)

District Office Staffing

Four of the five district offices we visited indicated that they are budgeted for a staff that is sufficient to perform required functions, including responding to complaints. The remaining district office indicated that it needs a 15.2 percent increase in staff to perform the required functions. However, the district administrators in all five district offices claimed that their inability to fill staff positions as vacancies occurred was the major reason for their

not responding to complaints promptly. However, we reviewed data on budgeted and vacant positions in the district offices and could not verify this claim in all cases.

We calculated the rates of staff vacancies in the five district offices for fiscal year 1980-81. We compared the staff-vacancy rates to the district offices' rate of late responses to complaints in calendar years 1980 and 1981.* Table 2 below presents our results.

TABLE 2

RATES OF LATE RESPONSES TO COMPLAINTS COMPARED WITH RATES OF STAFF VACANCIES

District	Percent of Complaints Received That Were Investigated Late	Range of Working Days Late	Allocated Staff Positions (In Months)	Number of Months That Positions Were Vacant	Percent of Allocated Staff Positions That Were Vacant (In Months)
A	42.3%	1-46	179	2	1.1%
B	35.4%	1-32	141	17	12.1%
C	51.2%	2-12	282	31	11.0%
D	20.4%	1-28	204	18	8.8%
E[a]	50.4%	1-184	732	75	10.2%
Total	41.5%		1,538	143	9.3%

[a] This district office stated that it was not budgeted sufficient staff to perform all of its required functions.

* Because staff vacancy data are available on a fiscal year basis only, we compared the staff vacancy rates with a comparable calendar year period.

Our analysis revealed that the district office with the lowest rate of staff vacancies (1.1 percent in District Office A) was above the average rate of late responses to complaints. Further, in the two district offices that had similar rates of staff vacancies (District Office C, 11.0 percent, and District Office B, 12.1 percent), we found that District Office C had the highest rate of late responses to complaints (51.2 percent) and District Office B had the second lowest rate of late responses to complaints (35.4 percent).

Consequently, although staff vacancies may have contributed to some late responses to complaints in each district office, we cannot verify that they are the sole cause of late responses. In some cases, complaint investigations were given a lower priority than the other required survey functions. In addition, district office supervisors do not always exercise adequate controls over complaint processing. One supervisor, for example, assigns complaints to a survey team and performs minimal follow up to ensure that the investigations are conducted. Consequently, some survey teams defer their complaint investigations until several complaints are accumulated or until the next scheduled visit to the facility. This practice resulted in many late responses to complaints.

Because the management at department headquarters has not monitored the district offices or provided guidance for the prompt investigation of all complaints, patients in some facilities have suffered harm for unnecessarily long periods of time. We found instances where decubitus ulcers had progressed to the bone or muscle when timely intervention could have halted their progression. In addition, we found that several facilities had not established a complete written plan of care for each patient; this resulted in inadequate patient care. One patient was hospitalized as a result of catheter treatments that were not properly monitored by the facility. Had the management at the LCD headquarters collected sufficient information for monitoring the district offices' activities, it could have identified those facilities with patterns of complaints involving physical abuse.

As indicated earlier, one district office took up to 69 working days to respond to four complaints of patient abuse filed against a single facility. These complaints were not validated. The district office investigated the fifth and sixth complaints within five working days and as a result of these investigations, it issued 29 Class "A" and Class "B" citations for serious commissions of patient abuse and neglect. If the district office had responded more promptly to the first four complaints, it may have been able to identify eyewitnesses

and document injuries. Because of the delayed response, however, patients may have suffered from physical abuse for periods of up to 69 working days.

DEPARTMENT PRACTICES AND PROCEDURES ARE INADEQUATE FOR ENFORCING MINIMUM HEALTH STANDARDS IN LONG-TERM CARE FACILITIES

The department needs to improve its practices and procedures to discourage facilities from repeating violations and allowing substandard conditions to exist. The department's practices of applying health standards and issuing citations, tripling fines for repeat citations, and enforcing Class "B" citations have been ineffective in ensuring that facilities do not repeat violations. Further, the procedures for approving facilities' proposed corrective actions and the follow-up visits to ensure that corrective actions are taken are not always effective. As a result, facilities are providing only temporary corrective measures and are repeating violations with limited threat of penalty. Moreover, patients may continue to be exposed to conditions that could endanger their health, safety, and security.

Both federal and state guidelines provide for periodic inspections of long-term care facilities to ensure that facilities maintain a minimum standard of health care. The Federal Health Care Financing Administration's State Operations Manual stipulates that surveyors should obtain an overall evaluation of an institution's performance and effectiveness in rendering safe, high quality patient care. The California Health and Safety Code provides for health

facilities to be surveyed periodically and notified of all deficiencies found. Further, the LCD's goal, as stated in the Policy and Procedure Manual, is to ensure quality health care services to each patient throughout the State by enforcing federal and state regulations.

The department assesses health facilities' compliance with state licensing and federal certification requirements and investigates complaints through the survey process, which is prescribed by law and regulation. The LCD survey team visits a facility to conduct an annual licensing and certification survey, a complaint investigation, or a follow-up visit. Further, the department issues a citation when the facility violates a statutory provision, a rule, or a regulation relating to the operation and maintenance of the facility. Along with issuing a citation to the facility, the department may assess a fine, within limits defined by the law. In some cases, if a facility repeats a violation for which it was cited within a 12-month period, the law requires the department to triple the fine for the subsequent violation.

The Health and Safety Code and Title 22 of the California Administrative Code outline the procedures for a facility to appeal citations. The facility can appeal a

citation at an informal citation review conference, normally held at the district office. Some facilities appeal directly to the Superior Court.

The department must notify health facilities of all cases of noncompliance with health standards. Then the facility and state department agree upon a plan of correction that allows for a reasonable time in which to correct the deficiencies. The department is required to make follow-up visits to verify that the facility has taken the corrective action described in the plan.

Facilities Repeat Violations of Health Standards

Our review of facility files shows that the department is not sufficiently discouraging facilities from repeating violations of health standards. The facility files revealed that, although deficiencies are shown as having been corrected, the surveyors frequently found the same deficiencies during a return visit to the facility. Our analysis of the facility files included examining the extent to which repeat violations occurred in the same facility. Any time we found that the "A" or "B" violations, the serious violations, were repeated in the same facility within any 12-month period, we counted them as repeat violations; however, we only noted those

"C" violations, the less serious violations, when they were repeated in two consecutive annual surveys. The extent of these repeated violations is shown below in Table 3.

TABLE 3

ANALYSIS OF REPEATED VIOLATIONS
FOR A SAMPLE OF 99 FACILITIES

Type of Violation	Total Number of Violations	Total Number of Violations Repeated Within the Same Facility	Percent Repeated
A	48	8	16.7%
B	147	16	10.9%
C	1,829	325	17.8%

Among the most frequent types of repeated violations were failure to provide patient care to prevent decubitus, failure to identify and develop patient-care plans, failure to notify physicians of unusual signs of behavior, failure to provide an adequate nursing staff, and failure to administer and record medications and treatments as prescribed.

The district offices do not consistently apply health standards, as evidenced by the inconsistent issuance of citations and fines. Long-term care facilities continue to repeat or only temporarily correct violations because the department's current policies and procedures are ineffective for enforcing minimum health standards. Also, the department

does not always triple fines for repeated violations or adequately review and verify the plans of correction. The Class "B" citations, furthermore, are not always enforced in court.

The Department Inconsistently Applies Health Standards

The department does not ensure that the staffs of the district offices consistently apply the regulations in Title 22 of the California Administrative Code. District offices have inconsistently issued classes of citations, and they have levied varying fines for similar violations.

The department may issue citations with fines for serious violations of Title 22 standards. Violations are classified into three categories according to the severity of the noncompliance. As mentioned in the first section of this report, violations that present imminent danger or substantial probability of death or serious harm (Class "A") are subject to fines ranging from $1,000 to $5,000. Violations that have a direct or immediate relationship to the health, safety, or security of a patient (Class "B") are subject to fines ranging from $50 to $250. Class "C" violations are those determined to have only a minimal relationship to the health or safety of patients, and are not subject to citations or fines. If during an inspection a survey team discovers deficiencies, the

surveyors determine which Title 22 regulation the facility has violated and then, when appropriate, issue a citation. The district office supervisors review the citation(s) and assess a fine.

We found that district offices issue different levels of citations and/or assess different fines for similar violations. The Health and Safety Code provides a definition for "A" and "B" violations, and the Policy and Procedure Manual explains the process of issuing citations. Other than these references, however, there are no department-wide guidelines that provide the staffs of district offices with criteria for issuing a specific class of violation or assessing a certain level of fine for various violations. Consequently, a surveyor may assess an "A" violation for a case in which another department staff member may assess a "B" or "C" violation or no violation. We found a deficiency discussed in the narrative portion of a complaint investigation; however, the facility was not formally cited for a violation.

For example, we found two facilities that had been cited for lack of adequate patient care to prevent decubitus; patients with advanced stages of decubitus had been found in both facilities. One facility was issued an "A" citation, and the other received a "B" citation. Other files revealed that

inoperative patient-signal systems had received a "B" citation in one facility, a "C" violation in another facility, and no violation in a third facility.

To examine further the consistency of applying health standards throughout the State, we summarized and presented to 20 district office staff for their analysis the results of six facility investigations. We presented examples involving patient care, maintenance of medical records, and maintenance of facilities. We asked the district office staff to evaluate the cases, and we compared their evaluations to the original results. We then compared the evaluation of the 20 staff members among themselves. District office personnel stated that our examples often did not enable them to identify a single violation or a certain level of fine, and they frequently cited several regulation numbers and more than one level of violation for the same example. We considered all answers cited in assessing the level of agreement in our analysis. (See the appendix to this report for a detailed description of this consistency questionnaire.) The level of agreement between the district office personnel and the personnel who originally investigated the facilities is shown in Table 4 on the following page.

TABLE 4

ANALYSIS OF AGREEMENT BETWEEN THE
DISTRICT OFFICE PERSONNEL AND THE
PERSONNEL WHO INVESTIGATED THE FACILITIES

Example Number	No. of Times Same Regulation Number Was Cited	Percent In Agreement	No. of Times Same Level of Violation was Cited	Percent In Agreement
1	6	30.0%	11	55.0%
2	16	80.0%	11	55.0%
3	3	15.0%	4	20.0%
4	1	5.0%	1	5.0%
5	18	90.0%	10	50.0%
6	19	90.0%	16	80.0%

The results of our analysis also show that variations existed both within and among the district offices.* For example, one district office administrator did not cite any violations for two cases. The same district office's supervisor cited an "A" violation and a "B" violation for the same cases. Further, the same administrator cited an "A" violation for an incident for which the supervisor cited a "C" violation. Where one district office administrator stated no regulation was violated, four others stated that they would have issued an "A" citation. For another case, one district

* Table 8 in the appendix to this report (p. A-3) provides a composite chart of the actual results by position and district office in selecting the level of violation.

office supervisor claimed that one regulation was violated, and another district office supervisor claimed seven regulations were violated.

In addition to issuing citations inconsistently, district personnel do not assess fines in a consistent manner. Some department headquarters staff and district office supervisors stated that the maximum amount of fines should be assessed. In contrast, one district office administrator stated that a range of fines should be assessed depending upon the severity of a violation.

When one facility is issued an "A" citation while another facility is issued a "B" citation for a similar violation, the district offices are not only issuing citations inconsistently, they are also assessing fines inconsistently. If a facility is issued an "A" citation, the facility becomes liable for a minimum $1,000 fine. However, if a facility is issued a "B" citation and subsequently corrects the violation, the fine is dropped.

The facility files reveal other examples of varying fines for the same levels of violations. Two facilities received an "A" citation for a lack of patient care resulting in decubitus, but the facility in which more severe patient harm occurred was fined a smaller amount. One facility was

assessed a $5,000 fine for five cases of advanced-stage decubitus found on one patient. The other facility was assessed only a $1,000 fine for an advanced stage of decubitus that resulted in the patient's leg being amputated.

Furthermore, the examples we presented to the 20 district office staff members revealed that supervisors assessed maximum fines more often than did administrators. Our review of facility files showed that although some district office supervisors stated they generally assess the maximum fine, four of five district offices actually assessed less than the maximum fine.

The department does not, however, monitor the district offices' citation activity to ensure that citations and fines are issued consistently. The department only reviews the level of citations and fines when a problem arises with a particular citation of a facility. (For instance, the headquarters staff have reviewed a facility's citation record because a legislator requested information on that facility.) The department also does not ensure that district office personnel monitor the citation process. District administrators stated that because they are involved in reviewing the citations at the informal appeals level, they

want to remain unbiased. In order to do so, they generally do not want to be involved in the citation process until the citation review conference takes place.

Another reason for inconsistencies in issuing citations and assessing fines is that the department does not adequately train staff in applying the standards of Title 22 of the California Administrative Code. The department does not train surveyors to issue citations or assess fines. The district office supervisors and surveyors expressed a particular need to be trained to write and document citations. Staff at the department's headquarters stated that although some citation training took place in 1979, there has been a 60 percent turnover in staff since then, and a current need for training definitely exists. In response to requests from district offices, staff from the Attorney General's Office and the department's legal office are currently providing training for documenting and issuing citations. The department expected federal funds to cover the cost of this current training program; however, as of August 12, 1982, department officials stated that they had not received these funds. However, no continuous provision exists for department-wide training of new surveyors or for regular refresher training courses for survey staff. The headquarters staff member also indicated that the department would save money if it conducted centralized training for new surveyors; however, this type of training has

not been implemented. According to this headquarters staff member, surveyors periodically travel to district offices for informational briefings, an arrangement that is more expensive than a centralized training program.

The department inconsistently applies health standards because it lacks adequate guidelines for interpreting these standards, because it has not monitored the citation process, and because it has not provided sufficient training to district office personnel. As a result, different levels of citations and fines are being issued throughout the State for similar violations of the same health standards.

The Department Does Not Always Triple Fines for Repeated Violations

The Health and Safety Code provides for the tripling of fines for repeat violations if a citation was issued and a civil penalty assessed for the same violation within the preceding 12 months. The department may triple the penalty regardless of whether the action to enforce the previous citation has become final. However, the department does not always triple fines for repeat violations.

Because this version of the law became effective on January 1, 1981, our attempt to determine the extent to which the department triples fines for repeat violations was limited to those which occurred after this date. Only 21 percent of all the repeated violations, however, were assessed tripled fines, as Table 5 below shows. "Repeated violations" are defined as violations with the same regulation number, including the same subsection number, that have appeared twice in the same facility within a 12-month period.

TABLE 5

REPEATED VIOLATIONS AND
THE ASSESSMENT OF TRIPLED FINES

Type of Citation	Number of Times Repeated	Number of Times Fine Was Tripled	Percent of Violations That Received Tripled Fines
A	4	0	0
B	10	3	30.0%
Total	14	3	21.4%

During our review, we discovered that some supervisors do not triple fines for two reasons. First, supervisors do not adequately review the history of a facility's violations before assessing a fine. Second, supervisors are not sure what constitutes a repeated violation.

When examining a report of violation, supervisors do not always review a facility's files to make sure that a similar violation had not occurred within the past 12 months. Some supervisors stated that they are familiar with facilities and review files only when they are unfamiliar with a facility's history of violations. One supervisor stated that he does not review files because each action against a facility must be supported by the facts alone. In addition, supervisors have limited resources for examining a facility's history of violations except for a review of the facility's file. (A detailed discussion of deficiencies in the LCD's management information system appears in the third section of this report.)

In addition, some supervisors are not sure what constitutes a repeated violation. One supervisor stated that he did not know if an "A" citation could be considered a repeat of a previous "B" citation. Another supervisor stated that he was not sure if a regulation number with a different subsection number could be considered as a repeated violation. The staff of the Attorney General's Office and the department's legal staff state that the law itself does not provide clear guidelines for tripling fines. The law does not address whether the same regulation number with different subsection

numbers can be considered as a repeated violation. Further, legal opinions differ about whether an "A" violation can be considered a repeat of a "B" violation.

Additionally, the Attorney General's current interpretation of the law prohibits tripling fines for corrected "B" violations. If a "B" violation is corrected within the specified time allowed in the plan of correction, the fine for the "B" citation is dropped. Consequently, because there is no fine once a "B" citation is promptly corrected, any fines for subsequent "B" citations cannot be tripled. The Auditor General's 1977 report pointed out the weakness in the legislation that allows these "B" citations to be continuously repeated without penalty.

Section 1428(e) of the Health and Safety Code, which covers the tripling of fines for repeated citations, was amended in 1980 and became effective in January 1981. The amended version states that a fine can be tripled regardless of whether the action to enforce the previous citation is completed. The department issued a memorandum notifying district offices of the change in this law, but the staff of two of the district office staff stated that they were unaware of this change.

As a result of the supervisors' not adequately reviewing facility files and because of their differing interpretations of the law, the intent of the law has not been carried out. Facilities are repeating serious violations that adversely affect patient health and safety. They are doing so without receiving additional penalties.

The Department Inadequately Approves and Verifies Plans of Corrections

The surveyors notify the facilities of all federal and Title 22 regulations that have been violated. Federal and state guidelines require the facility to submit a plan of correction for each violation cited. The surveyor reviews the plans of correction for acceptability and verifies that the corrective action is taken. At every district office, we found examples of plans of correction that were not sufficiently reviewed for appropriateness before being accepted. Additionally, district office personnel are not always verifying that corrective action was taken.

District office supervisors are required to review plans of correction for acceptability and to verify that the corrective actions were taken. According to a senior headquarters staff member, the facility must do more than simply state that it will comply with the law. The facility is

instead required to state the action it will take to correct the deficiency. However, plans of correction sometimes restate the law rather than specify the corrective action that the facility will take. For example, one facility had repeated occurrences of patient abuse; seven patients had been struck by another patient. As a result of these attacks, an ambulatory patient became bedridden with a fractured hip, another patient incurred a broken nose, and others received lacerations and bruises. The department issued an "A" citation to the facility for not treating patients with dignity and respect and for allowing them to be subjected to physical abuse. The facility's plan of correction stated, "Each patient will continue to be treated with dignity and respect in the future as they have in the past." The department accepted and approved this plan of correction.

The same senior headquarters staff member also stated that any plan for training to correct a violation should stipulate who will provide the training, when the training is to take place, what material will be covered, and who will ensure that the training is conducted. A facility's stating merely that in-service training will take place does not constitute an acceptable plan of correction. However, we found examples of in-service training being accepted as plans of correction, even though the plans for training did not include the required specific information. One facility submitted a

plan for in-service training as the plan of correction for 10 of the 17 deficiencies cited during an annual survey. Another facility submitted a plan for in-service training as a plan of correction for 11 of 15 deficiencies cited during a survey. These plans of correction were approved and accepted by the department.

Furthermore, we found plans of correction that lacked the required reviewing supervisor's signature. One supervisor stated that the surveyors were the only ones in his district who review the plans of correction. In addition, the department has accepted and approved inadequate plans of correction. For example, one plan of correction revealed that the purchase of an electric bug-catcher was an approved corrective measure for a patient with a maggot-infested sore. When interviewed, the district office supervisor who was responsible admitted that this plan of correction was not acceptable.

Finally, the department does not adequately verify that corrective action has taken place. A facility's proposed corrective actions are frequently approved even though the facility's past performance shows that the same corrective action was proposed previously for standards that were repeatedly violated. For example, one facility was cited for not having the minimum of 24 hours of documented in-service

training for nurse's assistants for three years. The facility repeatedly submitted a plan of correction stating that a new staff development director would be hired and would correct this deficiency. The plans of correction were accepted during these three years, but there was no evidence that the violation had been corrected.

In another example, a facility's dietary supervisor remained unqualified for over four years. The plans of correction stated that the dietary supervisor was enrolled in correspondence courses. The department accepted the plans of correction every year, even though the estimated completion date of the courses changed with each plan. Two district office supervisors stated that they do not consider this type of deficiency to be significant unless it is accompanied by poor preparation of meals for patients. In this facility, other deficiencies were in fact cited in menu planning and meal substitutions.

Because the department accepts inappropriate or inadequate plans of correction, and because it does not verify that facilities take the specified corrective action, violations of health standards may remain uncorrected or may be only temporarily corrected.

"B" Citations Are Not Always Enforced in Court

In general, the department does not pursue civil action to resolve appealed Class "B" citations. Through the appeal process, long-term care facilities can avoid any enforcement penalty associated with "B" citations, and the effectiveness of "B" citations is thereby diminished.

The "B" citation, with a fine ranging from $50 to $250, is assessed against a facility for violations affecting the health, safety, or security of a patient. If the violation is corrected within the time specified by the plan of correction, no civil penalty is imposed. Even so, some facilities are appealing these corrected "B" citations to the Superior Court. In most cases, however, the department and the Attorney General do not pursue "B" citations, but rather return the citations with letters stating that they will not be prosecuted at this time. The facility can therefore maintain that the citation was contested and not prosecuted.*

Our random sample of facility files contained 147 "B" citations, most of which were corrected within the specified time period. Thirty of the "B" citations were corrected and

* The Attorney General will prosecute all "B" citations that are linked with "A" citations received within the same year for the same facility.

appealed. Nine of these thirty (30 percent) were not prosecuted by the Attorney General. A representative of the Attorney General's Office stated that the percent of corrected "B" citations not prosecuted is normally even higher. Table 6 below illustrates the number of corrected "B" citations, unaccompanied by "A" citations, that were appealed as well as those that were not prosecuted. The table does not include the cases in 1981 that are still pending.

TABLE 6

DISPOSITIONS OF CORRECTED "B" CITATIONS

Year	Number of "B" Citations Appealed	Number of "B" Citations Not Prosecuted	Percent of "B" Citations Not Prosecuted
1980	165	127	77.0%
1981	88	74	84.1%

The Attorney General's staff member stated that the Attorney General does not prosecute "B" citations that have little or no fines because the amount of fines do not warrant the expense of prosecution. A member of the department's legal staff stated that the department concurs with the Attorney General's staff because the department is primarily concerned with correcting "B" citations rather than using resources to prosecute "B" citations in court.

The Auditor General's report of 1977 also addressed the lack of enforcing Class "B" citations, pointing out that the department expends resources to document these unprosecuted "B" citations. Our audit reveals that "B" citations are still not being prosecuted and that their effectiveness is thus diminished. Facilities may incur no fines for committing and repeating these violations. Currently, the only value of these "B" citations is to encourage facilities to correct a violation temporarily.

As a result of the department's inadequate practices and procedures for enforcing minimum health standards, conditions that adversely affect patient health and safety are recurring in long-term care facilities. Facilities are not sufficiently motivated to avoid repeated violations or to do more than temporarily correct a violation. Our audit results show that some facilities are continually in and out of compliance with health standards. The department is therefore not discouraging long-term care facilities from exposing patients to conditions that could endanger their health, safety, and security.

THE LICENSING AND CERTIFICATION DIVISION MANAGEMENT INFORMATION SYSTEM NEEDS IMPROVEMENT

The department needs to improve its management information system for licensing and certification activities. The current information system provides limited data for management purposes, and the system is not used to its full potential. The system does not provide the information required for monitoring and assessing trends of substandard care at long-term care facilities. Furthermore, the department lacks information and procedures for assessing the effectiveness of district offices and of the program as a whole. Such information and procedures could increase the efficiency of the department by quickly identifying current or potential problems in the program. Until the management information system is improved, the department may unknowingly allow substandard care to continue for prolonged periods of time.

Sound management principles dictate that the department should use accurate and timely information to identify trends of substandard care in its facilities and to identify state and district management problems. Additionally, Title 42, Code of Federal Regulations, Section 431.50, requires a planned, systematic examination and evaluation of operations

in local offices through visits, reports, and controls. The department has not designed and implemented an effective management information system to meet these requirements.

Limitations Exist in the Management Information System

The headquarters and the districts currently operate with limited management data and are not using the existing information system to its full potential. The department has developed the Facility Information System (FIS) for its operational units. The primary objectives of the FIS are to reduce operating expenses for maintaining facility licensing records and to meet information needs for essential program planning and control purposes.

For the management of licensing and certification, the FIS produces limited information. For example, of the fifteen FIS reports available for distribution to district offices, only three are used by district managers and supervisors. These reports are the Directory of Health Facilities, the District Office List of Health Facilities, and the Licensing Statistical Report. District administrators and supervisors do not use other reports because they have found the reports to be unreliable. Some reports do not contain useful information, and one report duplicated information provided by another section within the Licensing and

Certification Division. Also, potentially useful reports, such as the "complaint statistics" report, have been discontinued. The complaint statistics report was discontinued because of computer programming deficiencies and the difficulty in categorizing the complaints for the FIS.

Further, the department has neither an information system nor other procedures for monitoring and analyzing trends of substandard care in long-term care facilities. Districts do not systematically identify or analyze repeated deficiencies or complaints to identify facilities that require increased attention. The 1977 Auditor General report addressed a similar problem and recommended that the Department of Health Services maintain a profile or summary of violations of each skilled nursing facility to better detect repeat violators and patterns of noncompliance. The report also suggested that the department review these profiles for possible criminal or other appropriate legal action.

The department does not have procedures to gather objective information to track and assess routinely the performance of district offices. The 1980 Health Care Financing Administration's "Annual State Evaluation Report," which is the federal review of California's Medicaid Program, recommended that the State examine its current management processes to ensure that the management of the field offices is

being evaluated on a regular basis and that all areas of performance are satisfactory. However, the primary method of evaluating field offices is through monitoring selected activities such as facility visitation reports, citation reports, special surveys, and the decisions produced by citation review conferences. The monthly report on visits to facilities contains gross statistical data such as total visits made, visits past due, and complaint visits made. However, the report lacks the supplemental data necessary to assess the quality of performance. For example, the adequacy of the district's complaint processing could be assessed if additional data were available. This data could include the number of complaints that the district has received, the number under investigation, and the number that have been investigated. In addition, the data should include information on the timeliness of the investigations.

These limitations in information and analysis exist because the department has not assessed its minimum requirements for information. These requirements can best be determined jointly by the department and those who use the information. However, the department has not included district managers in the process of assessing needs, documenting requirements, and setting priorities for establishing and implementing an effective management information system. In addition, the department has not reviewed the Facility

Information System to identify and correct deficiencies. And finally, the department has not established procedures for assessing the performance of district offices.

Limitations Exist in the Analysis of Trends in Substandard Care

Substandard health care may go undetected and uncorrected if the department does not have adequate information and does not analyze this information for trends in patient care. Also, the lack of readily available information for highlighting the performance of district offices limits the department's ability to ensure the effectiveness of the whole program and to improve health care. Currently, the department cannot easily identify trends in substandard care, nor does it profile the performance of a facility or monitor the performance of multiple-facility owners. Our review identified problem facilities, according to the number of both deficiencies and repeated deficiencies. For example, in consecutive surveys, we found from 1 to 15 repeated violations of federal codes in 77 of the 92 (84 percent) sampled facilities. Also, approximately 18 percent of the violations listed in the first annual survey were repeated in the next annual survey. If the information system does not identify facilities that have problems, the department may not be able to ensure that facilities take prompt corrective action.

Because of deficiencies in the management information system, facilities may be providing substandard care for unnecessarily long periods of time. We analyzed nine facilities against which three or more complaints had been lodged. Our objective was to see if a correlation existed between the complaints and the deficiencies identified during surveys. We used only those deficiencies directly related to patient care, such as nursing and physician services. This analysis highlighted seven facilities with trends in substandard nursing services over periods ranging from 13 to 45 months.

As Table 7 on the following page shows, one of the nine facilities exhibited continuous or worsening trends in direct patient care over a 45-month period.

TABLE 7

PROFILE OF DEFICIENCIES AND COMPLAINTS
IN ONE FACILITY OVER A 45-MONTH PERIOD

1978	"B" citation (05/19/78)
1979	"B" citation (01/26/79)
	"B" citation (11/08/79)
1980	Complaint: 3 deficiencies (04/24/80)
	Complaint: 3 deficiencies (05/27/80)
	Survey #1: 10 deficiencies (11/03/80)
	Complaint: (12/23/80)
1981	Survey #1: plan-of-correction visit; 3 of the 10 deficiencies still exist (03/20/81)
	Survey #2: 12 deficiencies (10/21/81)
1982	Complaint: 13 deficiencies, 4 "B" citations (01/12/82)
	Survey #2: plan-of-correction visit; 6 of the 12 deficiencies from 10/21/81 still exist (03/18/82)

The facility files show that citations for substandard nursing services were given once in 1978 and twice in 1979. An investigation of 2 complaints in mid-1980 resulted in citing the facility for 6 patient-care violations. Further, in November 1980, the first survey in the file identified 10 patient-care violations, 3 of which were not corrected by the identified date in the plan of correction. In October 1981,

the second survey found 12 patient-care violations, 6 of which were not corrected by the identified date in the plan of correction. Three months later a complaint investigation resulted in the facility's being cited for 13 patient-care violations. It also received 4 "B" citations. A facility profile or other means of monitoring deficiencies and complaints could have identified this facility and other facilities having continued deficiencies that our review identified.

The department also lacks formal performance indicators and procedures for analyzing the performance of district offices. For example, the department cannot evaluate complaint processing because it does not gather data on complaints received and outstanding. It also does not gather information on the timeliness of complaint investigations, and the department may not be able to detect inconsistent district performance such as the assessment of fines discussed earlier in this report.

Potential as well as actual problems may go undetected in the district offices, too. In one district office, for example, we found that 73 percent of its annual unannounced facility surveys occurred within 14 days of the anniversary of the previous year's survey date. Because the

visits are so predictable in this district, facilities may meet minimum standards of care only during the expected period of the annual survey.

Further, for the department to evaluate the state program objectively, it will need to assess or combine data on the performance of district offices. Analyzing data by district may provide performance indicators. For example, the Health Care Financing Administration requires district offices to submit the survey documentation and recommendations for certification 45 days before the expiration of facilities' certification. Our sample of five districts indicated that one district always meets the deadline, but that the other four were from 4 to 76 days late about 20 percent of the time. If performance indicators such as meeting Health Care Financing Administration review deadlines were routinely analyzed, the department could increase the effectiveness of the licensing and certification program throughout the State.

The Los Angeles County Health Facilities Division Has a Systematic Process For Acquiring and Using Management Information

The Los Angeles County Health Facilities Division has a comprehensive management information system. The information that the Health Facilities Division collects includes 28 routine reports for managing and controlling its main

functions. The reports consistently provide information about issuing and renewing licenses and certifications, enforcement of health standards, investigations of complaints, and other facility data. The Health Facilities Division has also developed unique procedures for identifying and highlighting facilities that provide substandard patient care. For example, the Health Facilities Division has an accessible, automated profile of facilities that identifies trends in deficiencies, repeat deficiencies, and complaints. In addition, an automated list of deaths that occur in facilities is used to identify unusual occurrences that managers and surveyors should be aware of.

The field offices of the Health Facilities Division also maintain a list manually, by facility, of repeated deficiencies. This list allows management to identify and monitor trends of substandard care and determine whether civil sanctions may be warranted. In addition, the field offices maintain "patient care indexes," which are numerical ratings of facilities based on the facility surveys. The indexes are used to compare and rank the performance of facilities. They also help identify trends of substandard care, and they help assess the performance of multiple-facility owners.

This combination of automated and manual reports enables the staff to be constantly aware of substandard care. The Health Facilities Division staff stated that their information reports and procedures allow them to recognize quickly when civil sanctions or license revocation may be warranted. The staff also stated that the reports produced by the information system have led to more standard field operations and increased effectiveness because the reports identify weaknesses that warrant the attention of management.

The Department Has Taken Some Steps to Correct Deficiencies In Its Management Information System

The department began to correct some of the limitations in its management information system during the course of our audit. As a first step in developing a useful management information system, the LCD has started to collect data to be used in constructing profiles of facilities. Additionally, the department has formed a Facility Information System users' committee, which is attempting to determine if the FIS information is useful to the department and other agencies.

These actions had not progressed far enough to be evaluated during our review. Aside from these actions, as of May 1982, the department had no formal, coordinated plans or goals to systematically improve the overall management information system.

Future requirements for management information may become even more critical because of reduced federal funding. In fiscal year 1981-82, there was a $1.1 million reduction in federally budgeted funds for on-site surveys of Title XVIII (Medicare) facilities. These reductions resulted in the elimination of 23 consultants, surveyors, and surveyor trainees from the LCD's staff. In addition, the Health Care Financing Administration has proposed that the bulk of available resources be used to survey facilities whose performance is poor and marginal. Consequently, the State needs accurate and timely information to assess the performance of facilities so that it can focus on those facilities providing substandard care and thereby use its resources economically.

CHAPTER II

CONCLUSION AND RECOMMENDATIONS

The Department of Health Services, through its Licensing and Certification Division, is responsible for ensuring that long-term care facilities provide adequate health care for California's chronically ill and convalescent patients. The department is not satisfactorily enforcing state and federal health standards.

The department needs to investigate more promptly complaints made against long-term care facilities. The Health and Safety Code and department policy require the department to investigate complaints within 10 working days of their receipt. However, 41.5 percent of the cases we examined were deferred for an average of 33 working days and for as long as 184 working days beyond the required time limit. The district offices have developed inconsistent and sometimes inadequate procedures for investigating complaints because the department headquarters management has not provided clear monitoring and guidance for the timely investigation of all complaints. Although district offices state that staff vacancies prohibit their offices from always investigating complaints promptly, we could not verify that this was always the reason for late investigations. In addition, investigations of complaints were

sometimes given a lower priority than other required survey functions, and some district office supervisors do not always exercise adequate controls over complaints to ensure that they are investigated in a timely manner. As a result of inconsistent, inadequate, and untimely responses to complaints, patients have suffered for unnecessarily long periods of time from substandard conditions in some long-term care facilities.

The department needs to improve its practices and procedures to discourage facilities from repeating violations and allowing substandard conditions to exist. The practices of issuing citations enforcing "B" citations, and tripling fines for repeat citations, have been ineffective in ensuring that violations are not repeated. Also, the department inadequately trains staff in applying the standards of the California Administrative Code, Title 22. Moreover, department staff stated that the law does not clearly define which conditions constitute a repeated violation. Further, the department's procedures for reviewing facilities' proposed corrective actions and ensuring that corrective actions are taken are not always effective. As a result, facilities are providing only temporary corrective measures and are repeating violations without threat of penalty. Moreover, patients may continue to be exposed to conditions that could endanger their health, safety, and security.

Finally, the department needs to improve its management information system for licensing and certification activities. The current information system provides limited data for management purposes, and the system is not used to its full potential. The system does not provide the information required for monitoring and assessing trends of substandard care in long-term health facilities. The department also lacks information and procedures for assessing the effectiveness of district offices and the program as a whole. This information could increase efficiency by quickly identifying current or potential problems in the facilities. Until the information system is improved, the department may unknowingly allow substandard care to continue for prolonged periods of time.

RECOMMENDATIONS

To ensure that long-term care facilities provide quality care to patients, the Department of Health Services should promptly investigate complaints, strengthen its enforcement practices and procedures, and develop and implement an effective management information system. Specifically, the department should do the following:

- Develop clear, written procedures for assigning priorities to all complaints, including unwritten or anonymous complaints. These priorities should be based on the medical urgency of the complaint. In

addition, the department should define and establish investigation time limits for each priority level. Further, it should develop and implement standardized procedures for reviewing and responding to Medi-Cal Field Services Reports. The department should also collect sufficient information from the district offices to monitor their compliance with state and departmental requirements.

- Provide clear written criteria for assessing citations and fines, and provide periodic training for the interpretation and application of the Title 22 standards. The department needs to stress consistent criteria for issuing citations and assessing fines, and it needs to monitor district offices for compliance.

- Require district supervisors to review the history of a facility's violations when considering the assessment of fines; this will ensure that the appropriate penalties are assessed for repeated violations.

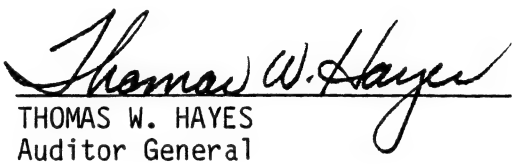
- Require better monitoring of facility plans of correction and the appropriateness of corrective actions; this will help prevent repeated violations.

- Conduct a review, involving district personnel, to identify their minimum requirements for information and reports. This review should also identify the district performance indicators that are to be monitored. The department should also review the Facility Information System to identify and correct deficiencies, eliminate unnecessary reports, and determine if the system can accommodate the department's present and future needs. Finally, the department should determine the costs of proposed changes in the information system.

We also recommend that the department clarify the definition of a repeated violation and clarify when a fine should be tripled. The department should specify whether one or all of the following should be cited as the condition for a repeat violation: the regulation section, the subsection, or the subparagraph.

Finally, the Legislature should amend the Health and Safety Code, Section 1424, to require a fine for a Class "B" citation even if the violation is corrected. Additionally, the Legislature should amend this same section to increase the fine for a Class "B" citation.

Respectfully submitted,



THOMAS W. HAYES
Auditor General

Date: August 20, 1982

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EDMUND G. BROWN JR., Governor

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August 19, 1982

Mr. Thomas W. Hayes
Auditor General
Office of the Auditor General
660 J Street, Suite 300
Sacramento, CA 95814

Dear Mr. Hayes:

The Department wishes to compliment the Auditor General staff for the professional manner in which the recent audit of Licensing and Certification Division, Department of Health Services, was conducted. We have reviewed the draft submitted to us. It is an extensive report detailing many complex issues, therefore, our comments should be considered as preliminary. While we do not question the need for review of the general target areas, we do question some of the specific conclusions because they are based upon untimely information. It should be emphasized that data from fiscal year 1980/81 was used as the basis for this audit; these data may not accurately reflect the current Licensing and Certification Division status.*

In view of the usage of outdated data, some issues which are raised as the result of such data have already been resolved, or are in the resolution process. We welcome the opportunity to comment concerning our intent to make further improvements in the enforcement of the laws and regulations by the Licensing and Certification Division. Such improvements will, of course, be designed to protect the health, safety, and security of California residents in health facilities.

Your report is critical of the degree in which headquarters staff monitor and review field office activities, such as citation and plan of correction procedures. In response to this criticism, it should be noted that the Division has already given strong consideration to the re-establishment of a program review function to be composed of the Field Operations Branch and the Special Facilities Team. The implementation of this function is now being pursued. A program review team would evaluate adherence to applicable standards and policies, and would be geared toward ensuring Division-wide uniformity. These reviews would provide guidelines for consultation and staff development needs.

The audit recommended that the Department should set up specific complaint investigation procedures; should set up a system for response to Medi-Cal Field Service Branch Reports; and should monitor district office performance in this area. The Department will review current departmental and divisional guidelines, and will revise or augment such guidelines as is determined necessary. Procedures for interfacing with Medi-Cal Division will also be pursued. In-service training of field staff will be improved. In this,

* AUDITOR GENERAL NOTE: Calendar year 1981 data is used throughout the report except for the staff vacancy analysis, where we used fiscal year information for comparative purposes. Staffing data was available on a fiscal year basis only.

and in several other areas, the Division is pursuing the implementation of a more comprehensive management information system to improve monitoring of field activities.

The audit also contained a recommendation that consistent criteria for assessing citations and fines be developed for the district offices, and that the system be closely monitored. More specific criteria for fines assessment is being considered, and when developed, will be reviewed by the Department's legal staff. Currently, citation training is being provided to district offices by the Department's Legal Office and the Office of the Attorney General.

A related recommendation was to ensure that the licensing history of each facility be more closely reviewed. A specific procedure for the review of a facility's history will be developed. This system will assure that facility files are reviewed prior to surveys, complaint investigations and assessment of citations. There are several systems now in place; each system will be reviewed and evaluated, with the result being a single Division system. The recent addition of a facility profile program to the Division's word processing system will also help to address this area of concern.

It was recommended that facility plans of correction be monitored and reviewed more closely. The development of such a procedure will be performed, and training will be held at an appropriate time after the procedure is finalized. Field staff will be provided instructions and training on the proper development of plans of correction. An evaluation and monitoring component will be included in the procedure.

The audit focused on the need for a more efficient information and report system. This is an area in which the Division has already taken some preliminary steps. A new Monthly Facility Visit Report, that provides basic management information by district, is being utilized; and the new word processing system has standardized preparation of statements of deficiencies. A facility profile has been developed via the word processing system. Also, the Chief of the Field Operations Branch has begun district office monitoring visits which will be done, at least, on a quarterly basis. Nevertheless, the Department concurs that a better management information system is needed. A "needs assessment" will be done to determine how best to meet the various information requirements of the Division. The District Offices will be included in this assessment. Once this has been accomplished, a feasibility study will be performed to determine how these needs can be met. Cost alternatives will be considered. Design and implementation will follow.

The final audit recommendation was to clarify the definition of a repeated violation. The Division is in the process of clarifying repeated violation procedures, such procedures will be utilized by field staff.

In conclusion, the Department plans to constructively address the issues raised in the audit, and, in fact,was already working on several of the areas at the time of your indepth review. It is felt that, in general,periodic staff shortages may have contributed to some of the deficient areas. To reiterate, it is felt that the usage of data from 1980 and 1981 does not necessarily reflect the current Licensing and Certification Division status. Moreover, it is our belief that the recent implementation of fee legislation for Licensing and Certification Division will allow the Division to perform at a high level of efficiency, and to achieve a maximum level of enforcement of health care standards in California.

Thank you for allowing us to comment on this report.

Sincerely,

Beverlee A. Myers
Director

cc: Health and Welfare Agency

CONSISTENCY QUESTIONNAIRE

We summarized and presented to 20 district office staff members six examples of results from actual facility investigations. Our objective was to assess the statewide consistency of applying the health standards contained in Title 22 of the California Administrative Code when district office staff evaluate health facilities. The staff participants included one registered nurse surveyor, one generalist surveyor, one supervisor, and one administrator from each of the five district offices we visited.

We randomly selected six incidents from the district office files and asked the department's deputy director to review and approve them for use in this consistency questionnaire. Because district office personnel stated that these summaries were often inadequate for determining a single violation, they frequently cited multiple regulation numbers and more than one level of violation for each incident. All answers for the assigned class of violation selected are shown in Table 8, page A-3. In some cases, more than one violation appears because the participants provided more than one response based on their interpretations of the exercise. Data are presented for each of the five offices.

To summarize again the types of violations: "A" violations present the imminent danger of death or serious harm; "B" violations have a direct or immediate relationship to the health, safety, or security of patients; and "C" violations bear only a minimal relationship to the health or safety of patients and are not subject to civil penalties.

The following are the examples of the facility investigation results used in the consistency questionnaire.

1. A complainant stated that a licensed vocational nurse hit a patient about a month ago. The allegation was substantiated via interviews and a review of written statements. The facility fired the licensed vocational nurse three days after the incident.

2. A nurse in charge complained that a Director of Nurses had ordered licensed vocational nurses to alter charts. It was alleged that once it was done to cover the death of a patient. Upon investigation, the surveyor found that several patients' health records were missing documentation from time to time. The surveyor found that licensed and certified nurse assistant's notes, both original and changed, were missing from the chart of the patient mentioned in the complaint.

3. A complaint was received in the form of an ambulance bill for services performed. The bill stated: "Dx: Seen in emergency room for maggots in ears--eating the skin--blood and pus drainage, urinary tract infection, and dehydration." During the investigation the patient's record was reviewed and the Director of Nursing Services was interviewed. The health record quotes the patient as saying his right ear was bleeding. The registered nurse examined the ear and found it to be full of maggots and pus. The attending physician was notified, and he directed that the patient be transferred to a hospital emergency room. The nurses aide's documentation stated that the patient had been showered on the morning shift; however, there was no documentation of an ear problem. The surveyor interviewed the Director of Nursing Services who stated that the patient had not complained of ear pain

or discomfort prior to complaining about the bleeding. There was no evidence of a urinary tract infection or dehydration.

4. A complaint stated that call bells were inaccessible. The surveyor found that although three call bells were inoperable, all call cords were accessible.

5. In September 1980, the bathroom water in four patients' rooms was between 127° and 130° F.

6. On a visit to the same facility in Example No. 5, on June 20, 1981, the surveyor found hot water in one patient's bathroom to be 134° F.

TABLE 8

VARIATION AMONG DISTRICT OFFICES
IN SELECTING CLASSES OF VIOLATIONS

District Office Position	Level of Violations Selected — Example Number					
	1	2	3	4	5	6
Administrator						
Office #1	--	A	--	C	B	B
Office #2	A/B	A/B	A/B	B/C	B/C	A/B
Office #3	--	B	A	C	C	C
Office #4	A/C	--	A/B	B	C	B
Office #5	A/B/C	B/C	A/B/C	A/B	A	A
Supervisor						
Office #1	B/C	C	A/B	--	B	B
Office #2	C	A	B	C	B	B
Office #3	B	B/C	--	B	B	B
Office #4	A	C	B	C	C	B
Office #5	A/B/C	C	--	A/B/C	--	C
Surveyor (nurse)						
Office #1	B	C	B	C	C	B
Office #2	A/B/C	B/C	A/C	B/C	--	--
Office #3	B	B	A	B	C	B
Office #4	A/B/C	C	A/C	B	B/C	B
Office #5	B/C	B/C	A	B	B	B
Surveyor (generalist)						
Office #1	C	B	--	B	C	B
Office #2	A/B/C	A/B	A	B/C	B/C	A/B
Office #3	--	B	B	B	--	B
Office #4	A	C	B/C	C	B	B
Office #5	C	C	A/C	A	B	B

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Director of Finance
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps